U.S. NAVY MEDICAL DEPARTMENT ORAL HISTORY PROGRAM
EDITED R. GINN, COL, USA, RET. 10/22/12

Beginning word count 24,884; 121 pages
Ending count 22,594; 114 pages

INTERVIEW WITH VICE ADMIRAL ADAM M. ROBINSON, USN, RET.
SURGEON GENERAL, U.S. NAVY 2008-2012

CONDUCTED BY
MR. JAN K. HERMAN, MEDICAL HISTORIAN, BUMED

28 FEBRUARY 2012
BETHESDA, MD

OFFICE OF MEDICAL HISTORY
BUREAU OF MEDICINE AND SURGERY
SKYLINE COMPLEX, FALLS CHURCH, VIRGINIA

This interview with VADM (Ret) Adam M. Robinson, former Surgeon General, U.S. Navy, was conducted as part of the Navy Medicine Oral History Program on 28 February 2012. It was conducted by Mr. Jan K. Herman, Medical Historian, Medical History Office, Bureau of Medicine and Surgery, at VADM VADM Robinson's home in Bethesda, MD.**Recording begins mid-conversation)**

A: I was born and raised in Louisville, Kentucky. Father and grandfather had been there. Grandfather came to Louisville, Kentucky from a small town in Kentucky in, I think 1889. He went to college there. He was a graduate in Greek and Latin at Simmons University, and taught school and was a principal in Kentucky early in the 20th century. My grandmother was from Kentucky also; St. Matthews. That's where my family was and that's where I was born and raised. My dad finished medical school at Howard. After he did his internship and residency in St. Louis he was at the Tuskegee VA hospital during the second World War, and after that then he came back to Kentucky.

Q: What about your first school memories -- elementary school?

A: Well, the first school memories for me were when I was in kindergarten, in an all-black school in Louisville. I was four years old at the time when I had to leave that particular school and go to a school that was much closer to my house, called Salisbury Elementary School. This was because Omar Carmichael, who was the superintendent of public schools at that time, had decided in 1955, right after Brown v. Board of Education, that Louisville Public Schools should integrate. That was a major step, because Louisville, Kentucky is a southern city. The way he integrated the schools is they allowed you to go to any school you wanted. If you wanted to go to a school outside of your district, you needed to apply, but you needed to provide your own transportation. The west end, where we lived, was predominately black; the east end was predominantly white. If you wanted to go to a school out in the east end, like Atherton, you could go, but you just needed to get there, and that was a pretty big hike.

So I ended up going to Salisbury Elementary School, and because of that move, I never really went to segregated

schools growing up other than kindergarten. Of course, what does a four year old know? I didn't have a clue. But it was just one of those interesting factoids that I realized as I got into high school in Louisville, "Oh, this is a very interesting thing." Carmichael was a very good superintendent; he had a lot of foresight, a lot of vision.

Q: What was your experience like in that school? Was it a good one?

A: Oh, I think my experience was great, and I think the reason my experience was so good is because my mother and father were absolutely determined that we were going to get a good education. My mother was very much involved in the schools. She became the president of the Salisbury Parent/Teacher's Association, and was very much involved in the day-to-day operations of the school and the administration. She was talking to principals and teachers, plus she had five children in that school. I had three sisters and a brother, and we were close enough in age that we were at one point all in elementary school together.

My sisters were several years older, so they got out very quickly and went to junior high and high school. But, my mother was very much involved in making sure that she understood what was going on and that we were getting the kind of education that she felt was worthwhile.

Q: So there was a tradition of education in your family based on your grandfather and your father.

A: Oh, absolutely. My mother eventually finished college. My parents met at Howard University. She came here from Florida, and she was enrolled at Howard as a student. They met when he was at medical school there in the mid-30s. So it was a definite influence. My uncles (my father's brothers) had both finished college at Northwestern University in Chicago. My oldest uncle, Carl, was a musician, a pianist, and he had gone to Northwestern in music, and then he went to Peabody and got his master's in performing arts -- piano.

My second uncle, George, was a Northwestern political science major, and then he got a master's in political science at the University of Chicago. My father was the only one that was having a tough time getting into college and getting through college. First of all, he failed his last year of high school; he failed French. He had to graduate a semester late, and that was a big crisis in the family at the time. Then he announced he didn't want to go to college. He was a great singer and he wanted to go to Fisk in Nashville. My grandfather wasn't opposed to Fisk at all, but my father wanted to sing in the Fisk Jubilee, the Jubilee singers, which were a very famous group at Fisk. My grandfather didn't want him to do that, This was is the 30s and he was like, "What are you doing? How are you going to make a living? What are you doing?" He said, "You're going to go to Northwestern."

But my father said, "I don't want to go to Northwestern." They finally compromised, and he said, "Okay, it has to be a Big 10 school." Why big 10? Because at the time in those years the Big 10 was fairly good about allowing black students to attend. So my father said, "Okay, you'll go to Indiana." So, he went to Indiana University and he got to Indiana and my dad was a great football player; he was really good. So, my dad went to Indiana, and he went out for the football team and made it. But he couldn't eat with the team; he couldn't shower with the team, it was really hard. This is 1928 now. So, he was having a hard time and he was pre-med, majoring in chemistry, and he was flunking everything, but he was playing football. So, finally the football coach said, "Robinson, I have a solution to your problem. I really would like to keep you on the team. Why don't you switch your major from pre-med to physical ed?"

My dad said that was what he was going to do; he was going to switch from pre-med to physical ed. He went home and he got on the train going home and he kept thinking, "Now, when I tell my dad, 'Hey Dad, I've got some good news. I'm switching from pre-med to physical ed.'" But my grandfather said, "That just wasn't going to be." When my dad came home he said, "Dad, I've made a decision, I'm quitting the football team." So, he came back and quit the football team. He finished his degree in chemistry and went to medical school.

Q: So he went to medical school and became a physician?

A: He became a physician, yes. He finished at Howard in 1937.

Q: But you didn't start out wanting to be a physician yourself? I mean, you talked about it but you had other ideas?

A: Yes, I did. You know, when you're growing up in a family and your dad's a doctor and I'm a junior, everyone said, "Oh, you're going to be a doctor, too" After awhile you say, "Sure, I'm going to be a doctor." But when I was finishing high school, I decided a couple of things. Number one: I was very good with music and was a member of the Louisville Jefferson County Youth Orchestra, where I played trumpet and French horn. I joined the Louisville Jefferson County Youth Choir and sang with the youth choir. I did solos with the youth choir, and then I got invited to join the Music School at University of Louisville, University of Cincinnati at Indiana; so I was going to go into music. I went to Indiana to see Roy Samuelson, a great baritone and a regional opera singer. In this country they have regional operas; there's the New York City Opera, there's the Metropolitan Opera, but there's also the San Francisco and the Houston; there are all sorts of regional operas. Samuelson had been a prime figure in regional operas and in New York for many years. He was the professor of music and voice at IU and he considered teaching me. I auditioned and he said, "Well, I'll take you as a student." But it was at my second lesson with him that I realized I didn't want to do music.

Q: Why?

A: He was very good, and what I realized was very simple. I think that he thought I had talent; I think he said, "If you really want to do this you could be good." We were trying to do an Italian aria, "Caro Mio Ben", but I couldn't get through the first four bars of that song, because he kept saying, "No, no, no, Adam, *caro mio ben*. He kept stopping me and stopping me and stopping me. Finally, after about 30 or 40 minutes, we finished the lesson, but as I left I thought, "Well, this is ending my music career,

because I don't have the dedication or the patience to do this." But honestly, this is the truth, I was 17, and I realized that the amount of the sacrifice I would have to make to do this was going to be a total consummation of me. In other words, I would have to put everything into it, and that's all I was going to do. I said, "I don't want to do that." And I never went back.

Q: So the one and only lesson.

A: Well, I had two. Fletcher Smith, a professor of voice at the University of Louisville, had coached me my whole senior year, He really wanted me to come to the U of L with him. Eastern Virginia wanted me to come there, and then Cincinnati -- my sister was at Cincinnati Conservatory in violin -- wanted me to come there. But I decided I didn't want to do that.

Q: So it wasn't just voice, it was any kind of music?

A: Well, I didn't want to do music. Music is very difficult. Not only is it difficult, but the history of music, music literature, music theory (music theory is very tough), composition, all of those things. You see, I wanted to sing, but I didn't want to go through all that, and it's as simple as that. So, when you realize that you don't want to make the sacrifice that you need to make, then you need to move on, because the only way you're going to be good at that is to make the sacrifice. Now, I did that in medicine, because I wanted to make that sacrifice. I wasn't going to do it for music; it's as simple as that.

Q: Were there any other alternatives for you? Or was it that or medicine?

A: Well, actually, no, because when I went to Indiana I majored in political science. I spent a great deal of time taking German literature, which I loved. I was very good in comparative German literature, and also anthropology. Why political science? I guess I loved political theory and political philosophy, but I'll tell you, I could have as easily gone into anthropology, because I thought ethnology and ethnography (which is one sort of anthropology-cultural anthropology) and physical anthropology: both of them were

fascinating. I took courses in both. I finally decided I'd rather be in the philosophy part of politics; I really enjoyed political philosophy. After my freshman year, I was invited to do senior and graduate seminars with some of the professors that I had. They allowed me to come and spend the summer with them doing that, and that was fun. So I decided to stay with political science.

My interest in politics really wasn't what we think of today. It was really Locke, Rousseau, Hobbs, the social contract theorists, John Stewart Mill, Jeremy Bentham. It was those types of philosophical debates that we've had for the last 500 years as to what constitutes society and social contracts, why we decide to live together, what is the purpose of the state, and how can the state and the individual actually live cohesively, etc., etc. Those are the kinds of things that I did enjoy thinking about and reading about at the time, including Plato and Aristotle.

Q: Were you thinking along the line of making this a career? Or were you thinking this is just kind of a neat thing to start?

A: It's interesting. I felt it was a neat thing to study. I had no idea what I'd do as a career, but I wasn't thinking that, I just thought, "This is the most enlightening stuff I'd ever read." And then my extra-curricular activities in school -- I always said I had none, I only studied, but that's not true at all. I had a lot, but it was all dealing with campus politics, and for me it was the residence hall. Indiana has a huge residence hall system. They have between 40,000 and 50,000 students enrolled in Bloomington campus, and about 20,000 or 30,000 live in dormitories, so we had something called the ISU Residence Halls Association, IRHA. This was a government that was associated with the residence halls. I became a member of the dormitory judicial board, the court that heard complaints, the students complaining against one another, students tearing up property, etc., etc. Eventually I became the chief judge of the system for the entire university, and I did that for a couple of years. Then the university made me an undergraduate residence assistant because of my two years on the judicial board. Students who got in trouble could ask for anyone to represent them that they wanted, it was

your right to get whoever you wanted. Some people went out and hired attorneys out of Bloomington, but I used to have a very excellent practice. I never lost a case.

Q: Well, it's a good thing you didn't go into law.

A: Everyone that was with me in those years thought I was on my way to law school. They used to go, "This guy's going to be really good." But I made a complete turnaround, and decided I really would like to go to medical school.

Q: What was it that made you want to go to medical school?

A: I've told people this for years and I really mean it. Medicine is like the ministry to me. What does that mean? If you're going to become a rabbi or a minister, a preacher, whatever you are, I don't care what denomination, you have to be called to do that. I mean, if you're sitting around saying, "That'd be really neat. I think I'm going to go get a church like Joel Osteen and make a lot of money," that doesn't work. I just got called to do medicine. I realized if I didn't become a physician I didn't think I was ever going to be satisfied in terms of my professional life. I needed to do that.

Q: Was it the influence of your dad?

A: I have no doubt that it was. My dad had died my freshman year, and I have no doubt that that was a major issue, but I have to tell you, I think it was more than that. I'd always said I was going to do medicine, then I said I wasn't going to do medicine, and then I became really overwhelmed with the prospects of doing medicine. I just wanted to do that, and I always felt like I got called to do that.

Q: Was this kind of an overnight thing that suddenly hit you?

A: No, it wasn't overnight. It was a slow two-year process, and what it took was getting away from everyone and doing other things first. I had an opportunity to do a number of other things: political science, political philosophy,

comparative literature, anthropology. I had a chance to go through the first two years of college and really explore all sorts of things and have a great feel for them.

The last two years of college weren't as much fun because I wasn't as good in the sciences as I was in history and other things. I had to take 10 hours of chemistry, 10 hours of physics, 15 hours of biology, and that was tough. I got all that done as elective hours to finish my degree, because I had basically finished my major in terms of all the courses that I needed at the end of my second year, which was 1970. I started in '68 and, of course, remember what's happening in '70? Vietnam was just raging, and my draft number was 43 or 44, something like that.

Q: You were sunk, that was it.

A: I was going to be drafted; I had a very low draft number. But, I went to medical school, and the reason I joined the Navy was because I had a low draft number. There was conscription in those years; I didn't want to be just taken, I wanted to join. I didn't want to hear, "You're going into the Army." I wanted to actually decide where I wanted to go. I had no problem doing it either, by the way. I wasn't upset about it, but I wanted to make the decision and I needed to pay for my medical school, so it was a no-brainer from my point of view. I applied for the Health Professions Scholarship Program in 1971, the first year that it came out (they actually funded it in 1972). I was in the first class of Health Professions Scholars, and that's how I paid for medical school.

Q: How did that work?

A: It worked beautifully. I think I got a $300 a month stipend, plus tuition, books, and fees. I had a little sky-blue Gremlin that I tootled around in. Gas, I think, was $.35 a gallon. I was living large; I had money to spend. It worked well because the Navy's Health Professions Scholarship Program is not onerous. Their whole position is do well in school and finish your education. That's the number one priority. The number one priority was not the military during those years in medical school; it was your

education. So, if something comes up during the summer and you can't come on active duty for the six weeks, that's okay.

The first summer I was at Indiana I came to Bethesda. It was my first time at National Naval Medical Center. I drove my Gremlin from Indianapolis to the medical school across the country for the first time between Indiana and Washington, D.C. I arrived at Bethesda and went to the old BOQ, which I think is Building 19 now, but the point is it's still there. I was an ensign and I got a room in the BOQ, and worked at the Navy Medical Research Institute (NMRI) for Tom Strickland, who was an internist. He also had a lab, and was doing research with toxoplasmosis. His office mate next to his office at NMRI was Captain Joe Cassells. Captain Cassells (later Admiral Cassells), who I saw once or twice, was never there. This was summer now, and it was a six-week rotation period, He was there a number of times but he was just not there when I was there; I never saw him in that summer period. It was interesting, because at that point he had started a PA (physician's assistant) program, and was working heavily with Duke University, which was establishing a PA program. I had no idea who he was or anything about this, but I remember quite well that he was doing that. I felt that was really interesting, and I felt the Navy was a very interesting organization. I thought, "My gosh, they partner with all sorts of different people. I mean, they're partnering with Duke University. That's a good school." I'm 21-years-old now, and I'm thinking, "This is neat."

Strickland was very good. We were doing toxoplasmosis research, and I liked it, but I didn't like it as much as I liked the parasitology lab, which was on another floor. I spent a great deal of time with the parasitologists, and I got involved with schistosomiasis, which was one of the things they were talking about.

This is the story of my life in many respects. I'm in toxoplasmosis, and I'm basically sacrificing mice and doing necropsies on them to take their liver and their intestines out. I could do that quite well, so I would get all that work done in the morning and complete what I needed to

there, and then I'd go racing down to the library into the parasitology references. I learned so much about schistosomiasis that summer. I was fascinated with parasitology, and I learned about schistosomiasis, jupanicum, haematobium, and mancinai. I could tell you the life-cycle of the sacaria, what snails that they lived in and if they were fresh-water oriented, I could tell you where the fresh-water was in Egypt, in Japan, in Asia, and in Tikirdian (?). I learned all this stuff; I just did nothing but that. And it's kind of interesting, because I couldn't tell you very much about toxoplasmosis now.

So, I got back and my professor, Gene Weinberg, (who's still alive, and still a wonderful mentor) asked me, "How was your summer. Tell me what you learned."

I said, "I was with Captain Tom Strickland in his lab and we did toxoplasmosis." I went through everything we did, and he said, "That's really great."

I said, "Yes, but that was nothing. Let me tell you what was really interesting." So I went through this schistosomiasis thing. I cleaned his stuff off his blackboard, and I brought out all the stuff that I had. When I finished he said, "I want you to teach the parasitology section in my medical microbiology course. Would you do that?"

I said, "You've got to be kidding me."

He let me teach the parasitology section of his course, specifically, schistosomiasis. That was a fascinating thing. I'll never forget that as long as I live.

During that first summer I also made rounds at Bethesda in the internal medicine floor and at Howard Hospital, and I learned a tremendous amount. I went down to the intensive care unit. Remember, this is the old Bethesda, so the ICU

and the way it was structured is completely different now. I had a great time working with the clinicians and the folks at Bethesda, and it was just very enjoyable. I didn't learn a lot of medicine, but I learned a lot about taking care of patients and families and interactions, and it was a great deal of fun. I had a ball. I was easily bored in those years, so I needed to continue to try to seek out new activities.

Q: So, you're doing toxoplasmosis, and then you're running over to the parasitology lab. Then, when you're finished there, you're going over to the…

A: Yes. How this worked is, during my six weeks with Tom Strickland he was an internist and an attending on the medicine ward. When he started attending, he said, "If you want to come over, you can." So I came over and he introduced me to people. I was a medical student, so I put my little white coat on, and then I started roaming everywhere. I'd just show up. I'd go down to the intensive care unit and start making rounds with people. This was August of '73. Nixon had resigned and Watergate was just raging, and I'm running around learning about schistosomiasis. It was a very interesting time.

A lot of the folks that I talk to now ask me what should they do? Well, here's what I learned out of that experience. I learned that Navy medicine has probably one of the richest traditions of research of any organization anywhere. Navy medicine has a research tradition that rivals many universities, and they have the capacity to do it in a couple of ways. Number one: with the Berry Planners, they ended up gathering some of the best of the brightest for a very short period of time. In doing that, they were able to capitalize on this wonderful wealth of information from those minds -- those ideas, that passion, that ability to get things done. Those men, and some women, would come in and absolutely reinvigorate the organization, In all of their craziness and all of that avant-garde and all of that abstract and obtuse ways of thinking and wearing Argyle socks with their whites, and all this other nonsense that they would do; they were great thinkers and great clinicians, and it really cross-fertilized a lot of what was happening. I remember Admiral Jacoby was the clinical admiral then, and at the time was having a major

feud at Bethesda with the commander. I don't remember who the commander was, but I remember Jacoby.

But, I can tell you -- and this was just an observation by a first year medical student and I didn't know much -- I think Jacoby could see the value of a lot of the people that were there, because we had a very wonderful transplant service at Bethesda in those years. Now, everyone died on that service, but they were trying to do bone marrow transplants, and they were trying to do all sorts of tissue transplants, but none were working. You might ask, "Why did they do it?" Well, the work that came out of that period is the reason we're so successful at transplants forty years later. I remember the host versus graft reactions, the tissue reactions, all of the problems. And I remember Jacoby. I remember the rounds, I remember the grand rounds, and I remember the conferences that I would go to where they would struggle to try to understand why the transplants failed. It was very dismal because families were crying, people were dying, and it was just awful. But, I can see now that that's how you make progress in terms of making a difference.

I didn't realize it then, but that never ceased to spur me on so that as I went through Navy medicine, as I went through training programs, as I got into a teaching position and a position of administration and leadership, I wanted to make sure that the people who I was with recognized some of the traditions of Navy medicine, which is probably, Jan, why I also was so interested in the historical nature of what we do as a way to make sure that the people who were with us recognize where they come from. Now, most people don't have a clue. I'm not saying that in any negative way, it's just that I think we (our generation, our age) owe them, what we know. It's our responsibility to leave them a legacy of knowledge regarding what we've done. This isn't an Army versus Navy thing, versus no, but the Army perhaps gets their story out better than we do. As Surgeon General, as commander at Bethesda, as commander at Yokosuka, I would hear people say, "Well, you know, the Army's doing all this wonderful work at Fort Detrick, and they have all these things going on." I would think, "Yes." And it's true; they're doing great work. But, the Navy has been doing just tremendous

work for the last fifty years. The basis of our training programs, the basis of a lot of our medical education and our medical department comes right from NMRI, the Navy Medical Research Institute, or comes from the NMOS, the Naval Medical Overseas Medical Institute. It comes from that tradition. That tradition hasn't ever stopped, but I think it has been forgotten or put on the back burner because of different people with different orientations.

Q: I'm not sure we ever looked at our history the way the Army did. I mean, they had guys like Bob Joy, who were promoting the whole concept of military medical history when we had nothing at that time.

A: One of the best courses I took at Indiana University was taught by a man named Fred Churchill. It was in the Department of History and Philosophy of Science. By the way, the Department of History and Philosophy of Science is one of the best in the country, if not the world. Dr. Churchill taught the history of medicine, and I was in heaven. I was learning things that I'd never learned before. It was an academic way of approaching this body of knowledge and categorizing it logically into wickets, or into places. And, I think, to Bob Joy's credit and to Dale Smith's credit, it was the same at USUHS. I always had an affinity for Dale, in particular. I knew Bob too, but the reason I wasn't closer to Bob Joy, even though I liked him a lot, was he was so Army-centric and I wanted more generic military medicine. Bob Joy was wonderful, he was just superb. Dale Smith was more of an academician in the sense of what I was used to from the History of Philosophy Science Department at Indiana.

Q: Well, that's his background. Bob Joy was a physician. He was made a professor, so I think that was why.

A: I think that's exactly right, and I'm probably stating the obvious. I always liked Dale's approach, because Dale wasn't a cheerleader for anything. He was a cheerleader for the history of military medicine, not the cheerleader of the history of Navy medicine, or Army medicine.

Q: Well, we always used to say that Bob Joy's lectures were not lectures, they were performances. If you ever went to one of his lectures, there was music, pictures, the whole thing; he was on stage, whereas Dale is more ecumenical when it comes to medicine. He doesn't necessarily sing a lot about Army medicine; he's proficient in all of them.

A: Dale's approach to history is very similar to yours. When you did the history of the Potomac Annex, you did the history of [Matthew] Maury, you did the history of oceanography, you did the history of what this facility meant to the early Naval officers. Where did they go after graduation from the Naval Academy in terms of learning navigation? Those are the kinds of things that are important to teach and to learn as opposed to, "I'm going to tell you everything that happened here, and I'm going to tell you what the Navy was." Well, you know, the Navy's the Navy and the Army's the Army, and that's fine. I liked Dale's approach, and I like your approach because I think that's important. I liked Bob Joy's approach from one point of view. I think he's very important, because he was such a cheerleader for the history of the organization that he loved, and he was willing to go to vast degrees to make the point. I can't take that away from him and he's due credit to that.

I know I'm getting way forward of where we are, but as I left the Surgeon General position as I finished my tenure, I heard from Trip Cassells, and I had lunch with him a couple of weeks ago. I said, "You know, Trip, it's really tough, because I really feel like many in the Army, and perhaps even some at the Uniformed Services of the Health Sciences, are pretty disgusted at me because of positions that I took in regards to the consolidation of the Army and Navy medical centers at Bethesda." Trip said, "Let me tell you something, the Army feels exactly like you do. They feel totally defeated."

"I beg your pardon?"

He said, "They actually feel totally defeated."

"You're kidding."

"Absolutely, they feel like they never had a chance to get Bethesda; they feel like they lost Bethesda, that they never had a chance to play in it, that it was never a level playing field. They're very distraught because they just feel like they've lost Bethesda." I stopped talking, and I said, "I'm not going to make any more comments to anyone else about how I feel."

I didn't feel defeated, I just felt like people were somewhat upset with me, but how can you be upset with me in this regard? I'm the Surgeon General of the Navy and I have Navy equities that I have to protect. I'm not the Surgeon General of the Army, nor am I the Surgeon General of the United States. I'm the Surgeon General of the Navy. There are Navy equities that I will never sacrifice in that position, and I always made that clear to everyone.

Q: It's just a matter of perception, I guess.

A: I understand that, but the perception is there. I will say one thing. I may not be the smartest guy on the block, but I'm pretty honest, and I'll tell you where I'm coming from. You don't have to wonder if I'm coming through that door or that door. I'll tell you what door I'm coming through, okay?

Q: Oh, I've known you for awhile. I would say that's pretty accurate.

A: And by the way, if I come through that door and you know I'm coming through it and I've told you I'm coming through, and you have the fire power and the way to stop it. That's my thing. I'm not a 0 Team 6. ??

Q: I wouldn't want to be a terrorist in your presence; I'm sure he wouldn't come out well. I want to talk about some of the decisions and how they were made. Of course, we always see it from one level and you can tell us from

yours. But getting back to your training -- you completed the first year of medical school.

A: I went through the first year, and here's the mistake that I made. I've told medical students this forever. I think it's a common mistake, but something to be aware of. I was so enamored with so many different things that I didn't take the time to manage my career, and here's what I mean. I became a Health Professions Scholarship student, and as part of that I became a Naval officer. Now, the problem that I had was I didn't understand what that meant. I didn't understand what the Navy was. I came on active duty during the summer and it was unbelievable what I saw. I was very happy with my choice of the Navy and the National Naval Medical Center. So, when I went back to school I was happy. I felt this was the perfect thing, but I didn't really manage my career by writing Captain Strickland, by writing Admiral Jacoby, by contacting people that I had met and setting up a little bit of a file -- nothing big, just a couple or three names -- and start communicating with them, start asking them questions, start telling them things I'd like to do, and starting a rapport so that they would know me and I would know them.

What happened is that at the end of medical school when we're all vying for internships, I was absolutely positive that I was going to come and do an internship at the National Naval Medical Center, because that's what I wanted to do. I'd been there, I'd seen it, and that's where I wanted to go.

Q: You hadn't vetted it yet?

A: Vetted it? I don't think I had one. I hadn't done any of the things you're talking about. I hadn't done any of that. So, I came out on a second trip to D.C to interview with the chief of surgery at National Naval Medical Center who had operated on Betty Ford. He had done her mastectomy (and I'll think of his name in a second), had multiple heart attacks, really a good guy. I'll never forget meeting him, I drove out to see him, and I interviewed with him for an internship spot. Now, what I didn't know is that everyone that they were selecting for internship spots were people that had been communicating with him, had been coming out here and had been regulars. But I wasn't a regular. I was

an interloper. I jump out of my Gremlin, and run up the steps. (In those years you could drive right up to the hospital, park, and just run in.) I went to his office and it was great, but he's sitting there talking to me and he's like, "Who are you?" It's more like, "What planet are you from, did you say?"

I'm there talking to him and there's no question I want to be a surgeon and I want to be in his department, and we talked. I'll never forget; he wasn't negative, he wasn't nasty or anything. He was a little aloof, it was sort of like it was a non-connect. It was just like I ran up and said, "Jan, I want to be a historian in Navy medicine."

"Okay, thank you very much. Is there anything else you'd like to tell me?" So, I'd done that, and, of course I didn't get selected.

Q: Did that come as a shock to you?

A: It actually did. I was very disappointed. As I think about how I used to think and do things, I just hadn't realized what I hadn't done. Now, this is also my nature; when that didn't happen, I had to get a spot so I went to Southern Illinois University, and all the things that I hadn't done for Indiana and for Bethesda I did there. The point is they selected me. I had a great year with them. It was a very instructive year, and I think it a very good year for me. I think the lesson learned was to recognize that things don't just happen because you want them to happen. You've got to work, you've got to plan, and you've got to have a strategy.

Q: When did that hit you? Was it after you were rejected and suddenly you realized you'd screwed up and you hadn't done what you needed to do?

A: I don't think so. I think that I couldn't understand at that point why I wasn't selected, but I'm telling you now I know exactly why I wasn't selected. I realized very slowly (and this took a little time) that I hadn't done any of those proper things to be selected, and that you have to

manage your career. You have to manage your affairs. It's not something that just happens, and that was a revelation for me.

You see, I had managed my career to that point by doing all of the right things -- taking the right courses, making the right grades, filling out the right applications, getting selected -- you know, doing all the right things. Well, it's more than that. You also have to make the personal touch; you've got to be a little bit of a politician, and that's what I didn't get.

Q: You didn't have a mentor. I mean, you had to learn this on your own by trial and error.

A: I did, and my mentor in those years, if I had one, the one that really started helping me was Gene Weinberg. When I came back, he helped me by saying, "Okay, teach the class." That was just the beginning of his many lessons. He said, "Okay, so this is what you did, so what are you doing now? What's your next thing?" I'll never forget how I met Gene Weinberg when I was at the end of my junior year and beginning to apply for medical school. Gene Weinberg had been really, really big in the medical science program, and was a very well-known professor on campus. IU had an experimental curriculum that would allow you to design your own course. You had to write a program plan; you had to write everything -- a curriculum…

(Part I-A, Recording ends)

(Part I-B, Recording begins)

A: …so I got all the paperwork for the School of Arts and Sciences, and I did everything. I plotted out the course. It was called Perspectives in Medicine, and I was going to go and get physicians from the community in different specialties to come and talk to the students about what they did, what life was like as a physician, their goals, and what was on their minds. It was one of those interactive things in which they would talk about being an otolaryngologist, or urologist, or obstetrician, or family practitioner, or a general surgeon. I wanted to have the students come out and then we could interact. "What do you

think is important? What should we be studying? What are your thoughts about different issues of the day?"

So, I had this thing and I went to Gene. (Years and years later he said, "Adam, would you please call me Gene." A couple of years ago when I was Surgeon General I relented.) I said, "Dr. Weinberg, this is my course," and I laid all this out. He's a wonderful, wonderful guy, very small but with just a huge mind, just wonderful. He looked at it and he says, "Well, I don't know," and he started critiquing it, but very mildly; he's a very gentle fellow.

I was always a little bit -- I don't know -- I didn't like his attitude. It was a little bit like, "This is my work here. This is damn good work; sign up for it or not. Move on, dot it or sign here." In those years I had a little Samsonite briefcase. "Well, Dr. Weinberg, thank you very much. If you won't do it, I'll get someone who will." And I started putting my stuff back in the case.

But he says, "Wait a minute, wait a minute," and he slowed down. But you know what? For such a powerful man, he wasn't angry; he didn't do anything. He recognized that a lot of what he saw in me was 20-years old. What did I know, Jan? I mean, come on, I wasn't a puppy, exactly, but I wasn't really full grown either, not mentally, at least. He calmed me down, and all of a sudden I realized, "Oh, he is going to help me." And then I realized, "Duh, he's actually critiquing what I'm doing and he's going to polish it now. I mean, I'm giving him this stuff and he's going to polish it up."

Well, I did the course for two semesters, and it was a sensational success. We had 30 students the first time, and the second time we had to close it at about 20. It was oversubscribed, and the physicians in the community really enjoyed doing it. It was great fun. We met at the university hospital in their conference room. Believe it or not, we did it in the early evening, but no one missed a class.

Q: And you were doing a lot of the teaching?

A: I did a lot of the teaching in that I introduced all the people. I knew who was coming; I gave a background on who they were and why they were there. I always had questions. I told the students, "I have these questions that I think are important, but what do you think is important? What do you want out of this? Why are you here?" The School of Arts and Sciences gave one credit, which is a pretty good deal. It takes 122 credit hours to graduate, but you know, you're one credit closer.

So, I did all the organization for all of the things in the course. And it's amazing. I always forget I do these things after I've done them, because I just go to the next thing. I had forgotten that I'd even done this until I started talking and then I remembered, "Oh, the experimental curriculum committee," and Gene Weinberg. That's how I met Dr. Weinberg, and then he gave me a place in his lab.

Q: So he became your mentor?

A: Oh, absolutely, no question about that. He not only became my mentor, he became my surrogate father. My dad was dead, and I never thought about it that way when I was with him. I don't even think about it now. The things he did for me were just incredibly wonderful, but I didn't realize it at the time, not really. I mean, I knew he was a good man and I loved being around him, but sometimes it takes age and distance to start you realizing, oh my God, this guy had really done amazing things.

Q: You have to look back on it from your experience to realize how important he was in your life. You wouldn't have known it at the time because you had nothing to compare it to.

A: Plus, you're so caught up in the moment with yourself that you don't realize the impact of people around you.

Q: Especially as a 20 year old.

A: Yes.

Q: You don't think that expansively when you're a 20 year old. You just think in the here and now.

A: Yes, I wasn't thinking expansively. And another thing, I wasn't all stuck up on myself. It was just me digging and driving and going, "Hey, you get on board or get out of the way." There weren't any in-betweens.

Q: So this is your second year of medical school?

A: Well, this whole experimental curriculum thing was as an undergraduate. Then, I got into medical school and we went from there. When I got into medical school, instead of going to Indianapolis, I went to the Bloomington campus. Indiana had, I think, the largest medical school in North America at the time, It was 300 students. That's a big medical school, maybe not that large by today's standards, but I think even today it would be a large medical school. The way they could do that was they had the bulk of the students at Indianapolis, and they had regional campuses at Bloomington, South Bend with Notre Dame, Muncie with Ball State, and Fort Wayne with Purdue. In my case, I did the first two years in Bloomington, and then my third and fourth year I moved to Indianapolis and I finished medical school there. So, my first two years of medical school, I actually stayed with Dr. Weinberg and I was with him a lot.

Q: So, he had a huge influence on your life?

A: Oh, absolutely, no question about that.

Q: You say he's still around?

A: He is. Dr. Weinberg's got to be 90, but he's still in his office every morning. I think he finished his 160th-something paper just last month. He is mentally still as sharp as ever, and as a matter of fact, in some respects I think he's even smarter than when I remember. He's just incredible. He's a great, great researcher. He is an expert on trace metals and iron, and if you look up Gene Weinberg, if you Google him, you'll get scores of articles on iron. He is an expert.

Q: So you keep in touch with him?

A: Oh yes, I talk to him probably once or twice a month, and his wife Fran.

Q: He must have been pretty pleased with the way his student came out?

A: Well, you know, when I went back for all the different awards the IU gave me in the last year or two, he was always there. They gave me a number of different things; it was nice.

Q: So you graduated from medical school, and now you have your Navy obligation. How did you transition into that?

A: Well, it's very interesting. I had my Navy obligation, but guess what? I didn't have a Navy obligation, because the war's over and I didn't get my internship, so I'm still a civilian at Southern Illinois University. I had a great year there learning a tremendous amount. I was a first-year surgery resident (or a surgery intern); however you want to say it. Internship is sort of passé; it's usually R1 now, first year resident.) The school asked me somewhere along the way if I would continue on as a general surgery resident. I started getting interested in doing urology. I was just a bit interested in urology, and they had a great urology faculty there. They took one urology resident a year, and the urology chief selected me; if I wanted to stay he would keep me. So, I had a decision to make, but the problem was none of that mattered, because the Navy decided that I needed to come on active duty. I had done my internship. Now it's time to pay back my time.

Well, I decided that I didn't need to pay back my time because there wasn't a war; there was absolutely no need to be on active duty.

Q: According to you.

A: According to me, and I was always right, Jan. But, they didn't need me. I mean, the war's over. It's 1976-1977, why wouldn't they just let me train here, finish, and then get me as a surgeon rather than later anyway.

I came out one day from doing a case at St. John's Hospital, and the operator was paging me on my pager. "Dr. Robinson, you have a very urgent call from the Bureau of Personnel," Now, she didn't say BUPERS, and I didn't know what she was talking about. She said the caller was a detailer and I said, "I don't know any detailers. Is this a drug salesman?"

"No, no, this isn't." Finally, he got through to me and he says, "Man, I've been trying to get you. I've been calling." Now I have to admit, I wasn't returning calls; I wasn't interested in doing a game with the Navy at the time.

He said, "I have to cut orders on you. This is really late. I'm going to be honest. You have two opportunities. You can take a ship out of Norfolk, or you can go overseas; I'll send you to Puerto Rico."

I said, "Norfolk, where's Norfolk?"

He says, "In Virginia."

And I said, "What kind of ship is this?" And he started telling me.

I said, "Ship or land? Is that all I have?"

He says, "That's all you have, and you have to make a decision now, right now." He had to cut orders. He was really pissed, he really was.

And I said "Well, I don't want either one of those."

He got exasperated. "I've got to tell you something. You're going to tell me something or the next conversation you're going to have is going to be with the U.S. Marshall."

Q: That got your attention.

A: It did. I must tell you, it did, and this wasn't about Miss Kitty. I wasn't thinking Matt Dillon [in the *Gunsmoke* TV series] I said, "Okay, U.S. Marshall."

He said, "You have a Navy obligation and by golly, you're going to serve your obligation. Now, tell me where you want to go." I tell you, the lights came on, and all the bravado and all the other nonsense kind of left. I said, "Yes, sir, I understand. I'll take Puerto Rico. Thank you so much." And sure enough, about a week later, my orders came for Ponce, Puerto Rico, Fort Allen. I would have to go through Roosevelt Roads to the branch clinic at Fort Allen; it was the only fort in the Navy at the time, and it had been a World War II base, Camp Losey. Now it was a Naval communications station for Mystic Star, which used to be the presidential communication system. They had a bunch of various classified stuff there. They had one doctor, a GMO, and they had about ten or twelve personnel, and that's where I went.

I got orders to Fort Allen, and I also got orders back to Norfolk for a two-week indoctrination course. What had happened in those years is people like me had decided that they needed to stay in school and not do OIS and a bunch of other things. I hadn't gone to OIS.

Q: You could have, but decided you didn't have time for that?

A: I should have -- okay, another major mistake. I'm serious as I tell you this now, there's no reason I shouldn't have gone, and the Navy should have simply said, "No, you're going to go to OIS. This is your class, and you must report."

And by the way, I wasn't the only one. There were a number of us that didn't do that. The way we're running the students today with Sam Yorksus? and the folks at NUXY? is like light years different and better than what used to happen. It wasn't anyone's fault, it's just a different world; it's just different how we do things now.

In any event, they had this two-week indoctrination course, It was very intensive. They really needed to work on us hard, because we were just an incorrigible bunch of nitwits; we just didn't know anything. People were coming down the first morning with epaulettes in the wrong direction, all sorts of different things. They got senior enlisted chiefs to go with us to buy our uniforms, and then showed us how to wear them, taught us how to get into formation, and to do a few things. It culminated at the end with Admiral Jacoby, who inspected us on our last day. After graduation we had orders, and I went with the psychiatrist who was going to Roosevelt Roads. I flew down on Eastern Airlines to San Juan. He got off and got a car over to Saba, which is where Roosevelt Roads was, and I took Puerto Rican Airlines to Ponce, which was about an hour and a half away by air over the mountains. So that was my first duty station.

Q: So you appeared at Fort Allen. How did you fit into that group?

A: I fit in very well. Fort Allen was 189 people, probably 110 families, a populace of 189 people that included dependants and active duty -- a fairly large enlisted population, all radiomen. The officers (the wardroom) was not more than 20 to 25 officers. The highest ranking officer was Captain Joust, who was the CO, and his wife Betsy. As an aside, I visited OIS at Newport several times as the Surgeon General. The last time I did it, about a year and a half ago, Captain Joust and his wife were there, and I paid a

tribute to them because he was a wonderful CO; he taught me a lot of things. So I got a chance to see him. He's very hard of hearing now, which is not unusual for tin-can sailors like him because of the engine rooms and the other things, but he's still a great guy, and Betsy's wonderful, and they have two daughters.

All the department heads (and I was a department head) were lieutenants. The CO was an O6; there was only one O6 there and that was Captain Joust. The XO was an O5, an aviator. Joust was a surface warfare officer; Muckenthaller was the XO. The communications officer was a lieutenant commander. Most of the officers were lieutenants, but there were a number of JGs and ensigns too. We were top heavy at the junior officer level, and very light at the senior officer level; it was a good way of entering the Navy.

Q: What size clinic was this?

A: It was a very small clinic. The daily census when I arrived, was probably 8-10 patients a day, but when I left, the clinic was seeing about 40-50 people a day. I did high blood pressure, I did diabetes, OB-GYN. I did specialty clinics in the afternoons, and I saw sick-call in the morning. Active duty sick-call always had head of line privileges, so that was usually like 7:30-9:00, that type of thing, and then I saw eligible family members from 9:00 on. And then we had appointments.

The person I relieved was Dr. Miller, and he didn't do a lot. I don't think people trusted him very much, but I didn't know this at the time. So, when I arrived there were a lot of patients that started showing up. By the way, that happens to all new doctors. If you go to a small town, it's not unusual for people to come in, because they want to find out who is this guy and what's going on. Over the course of time, we ran a really heavy clinic, and started opening up a lot of consultation lines with Roosevelt Roads specialists. It became a very active clinic, and I had a ball. I really learned how to practice medicine there.

Q: You're there how long?

A: Just a year.

Q: And then what happened? Where'd you go?

A: I went to the National Naval Medical Center Department of Surgery as a surgery resident. As I left Southern Illinois University, I was absolutely distraught, because I thought I was losing my professional career. I mean, I was a surgery resident. I was in a great program, I had done all this work and all of a sudden the Navy got me. And not only that, I'm not even doing any training, so what am I going to do next? I'm a general medical officer in a tiny clinic in Puerto Rico. I thought I shouldn't be practicing, because I didn't know enough. How in the world can they allow me to go practice with one year of graduate education past medical school? So, I got my current therapeutics in dermatology, current therapeutics in pediatrics -- current therapeutics in everything you can have. I had my whole shelf there. I'm reading like crazy and I'm doing all the audiotapes. I'm just constantly studying because, you know, I can't go down there and hurt someone.

When I arrived I found out that all the studying was good and the books were excellent. They were very helpful. But I also found out that you had to practice an old school medical custom, and that is you can read a lot, but you also have to just sit down and talk to your patients and ask them why they're there, which is a lot different than, "I'm having this terrible pain." It was a wonderful way of getting in touch with what medicine was about.

I then thought, "I'm in the Navy, so I'd better apply to a Navy training program." So, I called 8-SXY? and got 8-SXY to send me the forms for graduate medical education. I filled them out and did everything they said to do, and put them in the mail just like I'd done for college, medical school and internship, and sent them back to 8-SXY. I had my picture, little colored pictures on the forms, and it was really nice.

Q: This is still while you're in Puerto Rico?

A: Yes, I did this in Puerto Rico the first month I got there. I got there in July, and by August 15th or so I had my application in, because the cycle was beginning to start.

Q: This is ’77 or ’78?

A: This was August ’77. In September, maybe three weeks later, everything comes back; a thick, manila folder from 8-SXY comes back, and on it is a mimeographed sheet. Everything on that sheet is checked off: here’s what you failed, this is what we must have in order to process your paperwork. I think everything on that sheet was checked.

Q: So you had about 15 things you had to do.

A: The biggest problem was I did not understand you cannot process your own paperwork in the Navy; you have to go through your chain of command. So, I put my application in again, but through the Admin officer at Roosevelt Roads. The CO, the XO, the branch medical clinical director, everyone had to chop it.

But I also got this one back, and everything was checked off. I said, “Oh my God, what is going on?” I was really, absolutely, overcome. I sat there one afternoon and I looked at it. I didn’t know what to do. I just got really angry. I said, “To hell with it. I’m not suited for the Navy. I don’t need to be here.” So, I took the application and I threw it in the trash. As I sit here with you, there was a round trashcan by my desk, and I tossed it in there. I got up, got on my bike. (I was riding my bike everywhere in those years. It was a flat base.) I put my little khaki garrison cap on, and went back over to the personnel team. I said, “To hell with it.”

The next morning I came in, and I didn’t even think about it. It was just another day, and I’m in the clinic, I’d come in early in the morning. I used to smoke a pipe, and I’m there with my coffee and my pipe early in the morning. (In those years you could smoke in the clinic, I mean, this is ’77; it was a different world.) I’m sitting in there just puffing along, and I look down on my desk and there’s

the application. Someone had fished it out of the trash. Not only did someone fish it out of the trashcan, they had cleaned it up because I kind of crumpled it a bit. They cleaned it up and they put it out there right in front of me on my desk. I thought, "What in the world?"

About that time there's a little knock at the door. "Come in," and in pops HM3 Donna Bickerstaff from Dayton, Ohio, a wonderful person, excellent corpsman. She'd had duty the night before and was doing clean up; she emptied the trash and all that stuff. She said, "Sir, I went through your office last night. I saw that in the trash and I thought it had probably fallen off your desk. So I put it back there because I didn't think that needed to be there."

I said, "Thank you very much." When I closed the door I said, "Okay." I called Roosevelt Roads and talked with a Lieutenant JG Thompson, (I'm blocking his first name, but I knew him well; he was a great guy. He was a CO at, if I'm not mistaken, Buford.) I told him what was happening and he started laughing. He was a mustang, and he just laughed and laughed. He said, "Adam, put in the guard mail, send it to me, I'll take care of it."

"What do you mean?"

"Don't worry. I'll take care of it." Then he said, "You've got to do a couple of things a little differently if you're going to survive."

He got all the endorsements and mailed it from Roosevelt Roads to 8-SXY, and that was it. Then he called me back and said, "You've got to have endorsements." He gave me the tutorial and became a little bit of a sea daddy for me, telling me, "You can't do it this way." He was a JG lieutenant, but it didn't matter. There was also a guy there named Master Chief Boushee, who was a communications chief, and for whatever reason he got on my side early on. I don't know why, but he latched on to me and started coming by the clinic almost every day. He'd say, "When you

wear a uniform; put your belt around here. Put your devices on." My uniform was always clean and pressed, so that wasn't an issue, but you've got to do these things. He just started policing me, and it was very helpful. He was really very, very helpful, and I appreciate him a lot. I'll never forget him.

Finally, one day in January, about this time of the year, maybe a little earlier, the phone rings and it's Claude Atkins, who was the chief of surgery at Bethesda. He said, "I have your application here, would you like to come to be a surgery resident at Bethesda?"

I said, "Yes, sir."

And he said, "I have a position open, and if you'd like to take that I'd like to have you."

"I'd love to have it, thank you, sir."

And he said, "Please get here as soon as you can. There will be more information that will follow," or something to that effect "click". I mean, that call wasn't more than a minute, and if it was more than a minute it wasn't more than 90 seconds. And that's how I got to Bethesda.

Later on in the year, the medical IG team came to visit Roosevelt Roads, and they made a visit to the clinic. Admiral Milnes came to the clinic. When I got there, we didn't have a defibrillator; we didn't have a lot of things. Now, this is the 70s, so life was different. There were no AHA (American Heart Association) protocols for resuscitation. Things that we take for granted now were just beginning and in their infancy.

Q: This is '78, '79 already?

A: This is January ’78. Remember, I’m in a remote country. I had asked for and gotten a defibrillator. I had asked for a number of different things. I’d asked for a new x-ray machine because this was a very, very old clinic. I had all these different protocols that I was trying to start, and I had an SOP for the clinic. In any event, Admiral Milnes and a nurse came down, and he said, “My God, you really worked hard here. You have a great clinic. You’re really trying to be progressive.” I was very happy, because I had really tried, but I wasn’t trying other than to just see if we could get what I remembered from medical school in Indiana, from Memorial Hospital, from St. Johns Memorial. I was just trying to imitate what I had seen in every place that I had been. I said, “I’m in this old place. I’m not going to make it a medical center, but if you come in and you’re hurt or something, I want to be able to do certain things for you.”

So, I had a great talk with him, I’ll never forget him. Then he says, “Is there anything I can do for you?”

“Yes, sir, there is. I think I’m going to Bethesda as a surgery resident.”

“What do you mean, ‘think?’”

“Well, I talked to Captain Atkins, and then I got a letter that said I was going to go, but I don’t have orders. I don’t know what’s happening.” Now, this is probably the beginning of May.

He said, “Okay, I’ll take care of that.” It was sort of matter of fact, and he didn’t take notes or anything, and he left. I wasn’t pessimistic, I liked him a lot. But I said, “Oh my God, I’m never going to hear about this, because he doesn’t even know who I am.”

About a week later, I get a call from Bethesda, I get a call from BUPERS, and I get a couple of letters. All of a sudden, the world was kind of opening up and people were talking again.

Now, there are two lessons here. The first lesson is: be careful what you ask for, but it's okay to ask. The second lesson is: when you ask a flag officer to do something there's a lot of reaction, and there's a lot more that you don't know that may happen on the other end. Nobody was mad; however I think there was at least some irritation, because "Who are you to get Admiral Milnes, the Navy Medical IG, to call me and ask me why I haven't sent you this or why you don't have your orders yet? Your orders were scheduled for X; you were going to have the thing for Y." I didn't know that. I said, "Thank you, sir." And here's my answer -- I'm a different person now because I'm learning. "Thank you so much. I appreciate it." But as I hung up I said, "Damn right, don't let it happen again." I was a big man once the phone was down. But when the phone was up, it was, "Yes sir. No sir. I'm sorry."

Q: Maybe it was the U.S. Marshall thing that you were thinking about? You know, Admiral Milnes was a hell of a neat guy. He was a sharp guy.

A: I can tell you, he was somebody that I will never forget. I met him that time, and that time only.

Q: Bushy white eyebrows.

A: Bushy white eyebrows. He had this snow-white hair, very handsome, wore his whites, and I'll never forget his gold shoulder boards. I'd seen an admiral before, because Jacoby had done an inspection for us, but in Puerto Rico – I mean, the Navy IG came down. This was a big deal for the base because we didn't have officers visiting. The O6, Captain Joust, was the senior officer on the base, and the place was really far away, so it was a neat thing. That was a great experience. But he helped me get the information I needed on where I was going to go.

Q: I tell you what, we probably ought to end it here, because we've given you a pretty long session. We can pick up with you going to Bethesda for your surgical residence next time.

A: Oh yes, that's an interesting story too. As Surgeon General I would go to different universities, and I always wondered, "What do they want me to talk about?" In years past I've given clinical talks on a variety of different surgical topics, mainly in colon and rectal surgery, so I'm very used to doing that. But as Surgeon General, as you get higher in leadership, what they wanted to hear was exactly what you're asking me, and that is, "How did I get here?" The most frequently asked question was, "Did you want to be the Surgeon General and did you plan to do this?" The answer is unequivocally, "No, I don't know how you can plan to be Surgeon General."

Now, I know that there are people who want to be Surgeon General, so I guess I have to be fair. But in answering the question, did I want to be Surgeon General? I can tell you unequivocally, no, I never thought about it. Honest to God, I never thought about it. Did I want to be a flag officer? Yes, I did. I thought it would be nice to be a flag officer, but I never thought about Surgeon General, and I never thought of flag officer until I became a commanding officer, because before that I just wanted to be a commanding officer. I don't know if this makes sense. I was never planning for the big thing. My first thing was to finish surgery and get board certified. The next thing after that was to become a teacher at one of the medical centers. After that, it was to become a professor of surgery and to become really good in the field technically and from an educational point of view. After that it was to become chief of surgery at a hospital and a program director. After that -- and this is the wrinkle in the sense that, after that, I had stopped. I'm going to be a professor of surgery. I'm going to do surgery. That's what I've decided I'm going to do. But then Admiral Koenig asked, "Would you go to SURFLANT?"

"What's surf land," which is really the question I asked, because I didn't know the answer.

I called my old CO from Yokosuka, Walt Miner. "Captain Miner, what's SURFLANT?" He told me what it was, and I said, "They want me to be the force medical officer."

He said, "Congratulations." He was like, "That's great." So that was a new road for me in 1995. After that, I wanted to be a CO, but I couldn't be a CO at that point, because I'd been out of the medical center, I'd been out of mainstream medicine.

I would later get back into mainstream medicine as the XO of the Naval Hospital Jacksonville, and then as CO of the Fleet Hospital in Jacksonville, and lead a detachment of the Fleet Hospital into Haiti.

But I couldn't do that then, because I'd been out and I hadn't done the right things. I just couldn't get there. So, they said, "You've got to come to BUMED, because nobody knows who you are and they're not going to give you a command until they know who you are." So, I came to BUMED, and from there I went to DoD Health Affairs; and from there I finally got Yokosuka. So, you see, incrementally as it went along I was only after certain things. But after 1995 Admiral Koenig was the key, because I had never thought about doing anything other than surgery, and he let me be the chief of surgery at Portsmouth. Then I had gotten involved as the Medical Director at Portsmouth and was thinking in terms of that type of work, but it was still all at the medical center clinical level, it was still going to be clinically-attuned. Then Admiral Koenig threw me off completely by sending me to SURFLANT.

Q: When you think in terms of how things happen accidentally; I mean, Chief Bickerstaff pulling your application out of the trash. What are the odds of that happening?

A: HM3 Bickerstaff -- by the way, these stories I'm telling you are not embellished. These are not pumped up. This is what happened, and I've told that story repeatedly, because it was a sign to have Bickerstaff do that. Think about that. What if she hadn't? If she hadn't done that, I can tell you this, I do not think that I would have done anything other than to be a general medical officer in the Navy for whatever period of time I needed to be, and then gotten out, because my major goal then was to get training.

I had finally decided that "I'll get training wherever it comes, but I'm not filling this thing out." I mean, I was so deflated, it was "Oh gosh, what now?"

So I filled it out, got the pictures, did everything I needed to do -- but I didn't know what I needed to do. I thought I knew what I needed to do, and I had done what I would have needed to have done if I'd been in a civilian institution, but the Navy isn't a civilian institution. So it's a matter of you don't know what you don't know. There are all kinds of lessons in this. You have to get in tune with where you are if you're going to get in sync with what you need to do. If you can actually look at the possibilities of what you should and could do, all those things line up, but it takes flexibility in your thinking and the open mind to get you there. Thankfully, by the grace of God I got there with the help of Bickerstaff, with the help of Boushee, with the help of Thompson, with the help of a number of people that were standing around me simply saying, "Come here, son. Would you stop throwing mud pies long enough to come here? Come here -- slap, slap. Get over it. Wake up."

And that's what Koenig did. Koenig obviously said, "There is more potential in you than where you are now. Let me send you to this and we'll see." To be honest with you, at the beginning I'm thinking, "Why does Admiral Koenig want to ruin my life by taking me out of the clinical sphere of medicine?" Until 1995, I'd done nothing but clinical medicine. I did surgery.

Q: Well, that's what he realized. He said, "You're not going anywhere in this Navy in this medical department unless you get out of the clinic and do something else in leadership. He saw that probably from his own experience.

A: And you know what? He's a pediatric hematologist and he was exactly right. I bet you he was going to practice that when he left the Navy, but he certainly wasn't going to become the Surgeon General as a pediatric hematologist at San Diego, let's put it that way. You're exactly right, he saw that.

Q: Alright, let's call that it for the day.

(Part I-B Ends)

(Part II-A Begins)

Q: You left Puerto Rico, and you had just reported into Bethesda for your surgical residency.

A: Well, leaving Puerto Rico and getting the residency at Bethesda was, for me, a dream come true. I hadn't realized that the unaccompanied billet there was one year. The normal billets were two years, but I wasn't accompanied, I was by myself. The Medical Service Corps officer that helped me put my package together to send in my residency papers asked, "Why are you here in these quarters? This is sea duty, It's only a one-year billet for you." He helped me adjust the PRD, and then when the residency was offered to me, it was very easy to come back to the States. It was amazing. Things just sort of tripped into place, of course, with the help of the IG at the time, Admiral Milnes.

So I was excited to come back, but I had no idea what the residency was like at Bethesda. I remember reporting the first or the second day after I had arrived. I got set up in a house out in Germantown. I don't think the movers had delivered my furniture or any of the things from Puerto Rico, so I initially lived in a BOQ. I decided I wanted to check in, which was a mistake in a way, because in those years residencies were really ruthless. The minute that I appeared on the doorstep of the residency they wanted me to start working that day, right then. There were discussions with me in the Chief of Surgery's office. One of the residents said, "Can you be on call tonight?" I'll never forget -- and this is indelibly printed in my brain -- that I worked for the first six or eight weeks as a surgery resident in Bethesda and didn't have a bank account, because I didn't have time to get one. Finally, one day between cases I ran down to a bank branch in the bottom of the hospital. I banked there only because I could run down there and get things done and set things up. Now, this is prior to electronic deposits and all that other stuff. This was still snail-mail checks, the whole thing.

In any event, I didn't start that day, but within a week or so I had started and it was an incredible adventure. It really was very intense. It was probably the most difficult thing I've ever done in my life in terms of the commitment of time, the physical endurance, the emotional endurance; it was a tough, tough residency, and not the least of which I was the second black resident at Bethesda. There was a fellow named Maury McQuery sp?, who had finished the surgery program at Bethesda a few years before I did. Maury spent several years in the Navy, got out, came back and had more than a 20-year career in the Army. He did his residency at Bethesda, and he was the first black resident.

It's also interesting that there were two female residents at Bethesda: Diane Colgan, who today practices plastic surgery in Bethesda, and Judy Schwartz. I'm not sure where Judy is, but she was a cardiothoracic surgeon who trained at Bethesda and finished the program there. So, there was diversity in the surgery department; it wasn't a very traditional department.

I was not the resident chosen for the program. What happened is the resident that they wanted in their program had been an intern in the surgery department. He initially accepted the residency, then suddenly declined the position; I think he ended up going into family practice. So there was a hole in the residency. They needed to fill it, and that's how I got into the residency.

Q: This is general surgery?

A: This is general surgery, and it was a grueling experience. One of the traditions in general surgery was that you had changeover everyday at about 3:30 or 4:00 in the afternoon. I'll give you, very briefly, what it was like for a resident. It was seven days a week. Occasionally, you'd get a half a day off, and that would mean that if you were on call, let's say Saturday or Sunday, you might get off Saturday at 12:00 or 1:00 in the afternoon, which was rare. If you were really lucky, you might not need to come in on Sunday, but very often you would need to come in on Sunday, help round, and then go home.

In any event, it was generally every third day on call. On call means you stay in the hospital for a 24-hour period. There were no 80-hour weeks as there are today. My average working week as a resident was about 100 to 110 hours, in that range. As a chief resident, I literally lived in the hospital week to week, five and six days in a row, because we really were in charge of all the patients that were on our service, so we just stayed there with them. With that many patients, that many trainees, it was just easier to be there than it was to go home.

The 4:00 PM conference was a tradition. If you were the resident in the clinic, you were the admitting service for that day, which means that if you had clinic, you took all of the admissions from the emergency room and you were also responsible for getting your patients pre-OP'd for tomorrow, because the next day you were going to be in surgery. Your pre-OP day, which was your clinic day, was also your call day. So you would start in clinic in the morning; you would go down to the emergency room when you were beeped or phoned down there. The interns would initially respond, and the first-year residents would run down. Between patients in the clinic, you might run down and see patients in the emergency department, come back up, and get your senior resident. The senior resident would then get the chief resident, perhaps, the chief resident may get the attending -- there was a pecking order of how you worked. Everything was regimented such that you had to be very physically fit. It was a physically enduring process just to be on your feet for that period of time. Then you would go up and if you had cases the next day -- and generally you did because you were on call -- so you had a lot of cases.

Q: How many would you have?

A: Well, it would depend. The chief resident would put in, maybe eight or 10 cases. There might be three or four hernias, a couple of cholecystectomies, maybe a colectomy, maybe a pancreatectomy, maybe a spleenectomy, maybe a thyroidectomy, maybe a mastectomy. There might be breast biopsies. There were all sorts of different degrees of cases. The junior residents and the interns would get to

do, perhaps, breast biopsies, which were very difficult, believe it or not, as were hernias. We would get to do some of the less complicated cases, and the chief residents and the senior residents would do the more complicated cases.

The junior resident would almost invariably get to do hernias and cholecystectomy; this is prior to laparoscopy, so this was open cholecystectomy. You learned how to operate doing hernias and cholecystectomy. You learned how to dissect, how to find tissue planes, how to dissect through nerves and vessels, how to be gentle, how to use your instruments, how to use your fingers, how to feel, and, as they would say, to have eyes at the end of your fingertips as you would operate. It was very good training. Generally, a senior resident would lead you through, but very often you'd have an attending that would be there, that would teach you, particularly when you were first starting.

As you got older and had more complex cases, you would almost always have an attending who would then help you through those cases and teach you, It was a big deal to be a senior or chief resident and be involved with a pancreatectomy, or pancreaticoduodenectomy, a local procedure, or a gastrectomy, or a total colectomy, or abdominal perineal resection, that kind of thing. That was a big deal.

As a junior resident, when I would have a cholecystectomy, and it would turn into a choledochoduodenostomy, which would be a common duct exploration, very often I would call the senior resident in who would do that part of the operation, because he (sometimes she) may not have done very many common duct explorations, and they could come in and do that one.

Often they were tied up and couldn't come, therefore I would do it. That was always a joy, because I would get to do not only the cholecystectomy but the common duct exploration, to extract the duct, do the cholangiogram,

place the t-tube, do all those things that you'd need to do.

Q: And the attending would be supervising this?

A: The attending would supervise, yes. You see television and hear all sorts of stories, but in my experience in surgery at Bethesda, I will tell you I think I had extraordinarily good training. I mean, it was intense, but the intensity wasn't just to be brutal. The intensity was to emphasize and underscore the amount of responsibility that you had as a surgeon, and the responsibility you had to be prepared to operate by yourself in isolated places underway at sea or in war zones. No one said, "I'm getting you ready to be in war," or, "I'm getting you ready to be underway at sea." No one ever said that. That wasn't ever discussed. It was just the intense, episodic events that would allow you to recognize what your responsibilities were.

I've often said that I think that my first two years in general surgery, and my general surgery experience in general, was an experience of being taught by negative reinforcement. I do think that's true, because everything was placed in such an aggressive and somewhat punitive method of operation. There was no love lost; there was no "joy in Mudville". It was quite intense, and people really stayed on you with a ferocity that made many people quit. When I think about that ferocity and that intensity, if I could give you a parallel or an example outside of medicine, I think it's not unlike Marine Corps boot camp. I think it's not unlike going through the Crucible in the Marine Corps. I don't think it's unlike going through the types of things that we send our young enlisted sailors through at the end of their enlisted training, which is very intense and very quick. It helps to build a team and to understand what your position is in the team and how you're responsible as a shipmate for everyone else. In a strange way, I think the surgery residency together with both the traditions of surgery outside the military, plus the military traditions, made for a very intense residency.

Then there were the out-service residency places that we went to. For example, the tradition when I went through

Bethesda, was to do your pediatric surgery at Children's National Medical Center. In my years, Jed Randolph was the chief, and his assistants were there, and I'm blocking the woman's name who became the president of the American College of Surgeons [Kathyrn D. Anderson, M.D.] who was just superb; she was wonderful to work with, and her colleague, who became the chief of surgery at Children's Hospital in New York. It was a wonderful group of people, absolutely superior surgeons, surgeons of the first order, with not only incredible technical skill, but the ability to understand who's sick and who's not. Technical skills are important, no question. But one of the things you have to really be able to do (this is going to seem almost trite but it isn't) is you have to understand who's sick and who's not. Believe it or not, not everyone can do that. It takes a lot to understand who's sick and who's not.

The second thing is it really takes an incredible amount of time and experience to figure out how to systematically go through the processes you need to go through in order to make the diagnosis. General surgeons are very good at that; even today, general surgeons are very good at that. I'm not going to suggest, nor am I saying to you that they outstrip the internists, or they cause all the people to cower, but if you notice, in most situations the sickest of the sick generally go through on the general surgery service. The folks that have the hardest things to diagnose and understand often are put on the general surgery service. People who are in chronic pain almost always get put on the general surgery service to start, until they figure it out. Abdominal pain is always a general surgery issue. I'm not suggesting that all abdominal pain is general surgery, I'm just saying that if you come in with abdominal pain, I guarantee you you're going to get a general surgeon.

Q: Is the philosophy the fact that a general surgeon has to be pretty well aware of the whole patient, that he's got to be aware of the mechanism, the human machine, and not focused on a particular area the way a specialist is?

A: Well, I think that that's true. The general surgeon at the beginning of the special term "general surgery" did everything. The general surgeon did neurosurgery, he did abdominal-surgery, he did ENT surgery, he did cardiac

surgery or thoracic surgery or abdominal surgery or plastic or breast or soft-tissue. He did lymphomas, he did sarcomas, he did all sorts of different tumors, he did pediatric surgery, he did orthopedic surgery, he did neurologic surgery, and that's the truth. So, general surgeons, and even to this day, are very good at diagnosis. For example, a surgeon that was with me at Bethesda, and at Portsmouth when I was the chief there, was Allen May, who's famous. He finished at Rochester, and he was a pioneer in vascular surgery, and specifically in transplant and kidney transplant surgery. He was a resident of Charles Robb, who was a very famous British and American surgeon, who cared for many, many dignitaries: Winston Churchill, Edward VI, many people in Great Britain, then came to this country and became an American citizen, was the chief at Rochester, and was also a distinguished professor and a surgical consultant at Uniform Services University, where I had a chance of working with Dr. Robb for many years.

Q: Couldn't have been a spring chicken at that point?

A: Dr. Robb died, I think, in his late-80s or early-90s. When I knew him he was in his early-70s, maybe mid-70s. He did not operate anymore, but he always came to the operating room and was able to give the most incredibly, wonderful consultations to help you understand where you were, what you were doing, and how you may be able to do it differently, or had you thought about a few things, because, this was a man that had done everything. The general surgeon of Charles Robb's era did everything. When Charles Robb was in the Second World War with the British, he did everything. He did orthopedic surgery, he did neurosurgery, he did whatever was needed.

Q: In a sense, they had to be adept at everything.

A: They had to be adept at everything. Now, from that, of course, arose the whole era of specialization, because it became much easier. If you think about it, I can do everything and be master of nothing, or I can master something, but once I master something, then all of a sudden I'm tunnel-visioned into that one thing. The country doctor, Gunsmoke's Doc Adams, is probably the reason that I always loved that show. I liked that character. He represents to me someone that did everything. He did

anything that came in the door. I'm not suggesting that he always did it well, and I'm not suggesting that he always did it right, because he didn't know a lot of things; he had none of the tools we have today, no X-rays, no laboratory. He had physical examination and he had clinical experience, and he was able to put those two things together to make a really fine physician. And the most interesting thing is that that philosophy makes really does make for a fine physician.

When I was in Puerto Rico my first year, I had a 1942 Picker X-ray unit that leaked X-rays and worked sometimes, but we got it to work. I didn't really have a very robust lab. We could only do hemoglobin, hematocrits and specific gravities of urine, and I could look at the urine for red cells and other things under the microscope. I'd come from an institution at Southern Illinois University in which we were just installing our first CT-scan unit. This is 1976, and we were getting away from doing carotid injections for carotid angiograms to look at whether the center cavernous vein system in the brain had been shifted, which would then let you know, indirectly, that there was a mass effect and you probably needed to operate on a subdural hematoma. You couldn't see it because we didn't have the technique to do that when I first started as an intern. But when I got to Puerto Rico, I recognized there is a heck of a lot we can do by physical examination and history that gives us the ability to do much, much more than we think. The other things that we do in medicine are important, and I'm not discounting them, but I would suggest to anyone that when you go out and you start using your skills, your senses, and what God gave you and what you've learned from your experience, it's better.

Q: I remember interviewing a surgeon from the Korean War, who was in field hospitals close to the front. I was amazed to learn they had no X-ray machines, and for every suspected fragment they had to palpate and determine whether there were fragments. If they were in the cranium, there were problems because they couldn't see them. Anywhere else, any kind of a fragmentation, shrapnel, whatever, had to be felt.

A: So they had to feel it, and do what you would conduce in general surgery. In the abdomen, if there were penetrating wounds to the abdominal wall, then you would run the bowel, which is a very standard thing in surgery. If you saw a puncture wound in the small intestine, you'd see a puncture wound in the abdominal wall, and you'd see a puncture wound in the intestines. You then had to look for the exit wound. All your wounds have to have an even number of wounds. So what you would then do is try to figure out all of your wounds, and then try to figure out all of the shrapnel, all of the bullets, or whatever the projectiles were. Now, it doesn't mean that you always got your projectiles, but if you end up with, let's say, 13 holes in the gut, I'm telling you there's an issue, there's a big issue. So you would just have to continue to search until you found the 14th.

Q: Either that or account for the fragment.

A: You have to account for the fragment; you have to account for exactly what was happening, that is correct. So, I digress. The reason I went into this was the intensity of the residency and what the preparation was for. The first year of the residency was very tough, because Ed Woods, who was my running mate, and myself, were the only two residents, but traditionally there were three. A third resident had been selected who they had agreed couldn't fill the position, but I don't exactly understand why. So Ed and I for the year we were on the general surgery service ended up doing port-starboard watches in terms of call, because there weren't three of us. We didn't have call every third day. It was every other day; and that was really, really a tough period. But, I endured it.

The toughest thing, though, was I felt really put upon. I think I was pushed harder for a couple of reasons. One is I wasn't as smart as everyone in terms of I needed to read more, and I wasn't always able to answer with the correct answers. I didn't complain. I was a hard worker, but I also think that there was a real effort to test my limits. I feel like there may have even been an effort to get me out of the program by just making it very difficult and intense. I think maybe that had to do with color. I don't

know that for sure, but I think that that may have had a major impact.

I will also say that no matter where you are, people talk about mentors. If people say, "Well, I want you to be my mentor because you're African-American, or you're a man, or you're a captain, or you're an admiral, or you're Jewish or Catholic, or you are something," that doesn't mean a thing in the sense that a mentor can be anyone. It can be any sex, so you can have a woman or a man, it doesn't matter. Religion, race, none of that matters. There were people in the hospital in those years who mentored me. For example, I have to give a tribute to a group of ladies down in medical records. They were almost all black, and they were like my, big sisters or my mother -- they would keep their eye out for me. If at any time they heard anything, or if my records weren't all there, or if there was any problem, they would come up. I was around the hospital night and day, and they'd come and get me, or they'd bring my records up and they'd say, "We're not supposed to do this, but here, sign your records, sign everything here. Get your records done because the chief surgeon's on a rampage now and he wants to know all the residents that don't complete their records, and you have more records than anyone else." They were just so good at helping me to do what I needed to do, and I always appreciated that.

Then Bob Cochrane, who was the chief of surgery, finished me. He took over in 1980 as the chief, and was really one of those guys who was so hard on me and just gave me hell. But at the same time he was wonderful to me and actually protected me, and made sure that I got what I needed. He always took care of me. But I tell you, it took me a long time to realize that he was my friend.

Q: He was the chief of surgery?

A: He was the chief, but in those years, before he was the chief, he was the assistant chief. He was a team leader, and a team leader was a senior surgeon. He had a major job because he was the staff surgeon. We had blue, gold, and red teams; red was vascular, blue and gold were the general surgery teams. Bob Cochrane was the blue team leader, and

Don Stewarts was the gold team leader. Don was also very good, but Bob Cochrane -- there was a special affinity for Cochrane.

I'll never forget when I was a third-year resident. I hadn't done as many cases as everyone else because I had been excluded for a variety of reasons. I'm not sure that I always understood all the reasons, but I think that they had very little to do with my technical capabilities. I think technically I was fine, and it had very little to do with my intellectual capabilities. I just think that people were taking advantage when they could.

Cochrane called down the chief resident about a woman that had come in who needed a thyroidectomy; she had a solitary thyroid nodule and she needed to have a partial thyroidectomy, or a thyroid lobectomy. I had worked her up and was ready to do it. The chief resident, Mike Denson, who was my chief resident at the time (he's a plastic surgeon now in Bethesda) was notorious for being a case hog, just notorious. He'd turn nothing down but his collar, as we used to say. I had done hardly anything and he wanted to do everything.

(Part II-A recording ends abruptly)

(Part II-B recording begins)

A: So there was a lady that came in and needed a thyroid lobectomy. There was a junior attending by the name of Hal Sessions, who was an interesting character in and of himself. Hal had been a junior staff, and was staff at the time. He'd finished, and he was an excellent surgeon, just a wonderful technical surgeon, really good. He had always been a thorn in my side, and he kept calling me down one day and he said, "How many thyroids have you done?"

"I haven't done any."

"You're a third-year resident and haven't done any thyroids?"

“No, every time I get a thyroid, somebody takes it.”

“Well, this lady’s coming in. Go see her.” So, I went to see her and when I got through working her up, my beeper rang and there was Mike Vincent, the chief resident, “Hey, come on down to my office.” I went down and he asked, “What are you doing?” I told him what I was doing, and he said, “Oh, I’m going to do that case tomorrow.”

I said, “You took that away from me?”

He said, “Yes, I took it away. I’m doing that case.”

And I said, “I haven’t done any.”

And he said, “I’m sorry, your time will come. You’ll have yours next year, but this is mine.”

I said, “Okay.” About an hour later the beeper went off and Cochrane calls me. He says, “Robby, how many thyroids have you done?”

“Dr. Cochrane, I haven’t done any.” I had a feeling that Hal and the boss were talking.

“Well, you’re doing one tomorrow.”

And I said, “No, I’m not. Chief’s taking that one.”

“Nope, that’s yours.”

They took that case away from Mike Vincent and I did it with Bob Cochrane. The lady did perfect. It went exceptionally well; everything went fine. Mike always thought, probably thinks to this day, that I complained. But I didn't say a word to anybody. I didn't make any funny faces, I didn't roll my eyes, I didn't do a thing. I did exactly what I'd always done, and that is just go back to work, and because I had so much damn work to do, it didn't matter.

Q: So, what do you think transpired between the two of those guys?

A: Well, I'll tell you exactly what happened. There was a discrepancy with what I was being allowed to do. The discrepancy wasn't over my capabilities. I think the discrepancy was over other things. To be very blunt, I think that there was a real feeling that, "We can get by without giving Adam his due because he doesn't deserve this." But my patients loved me. My cases went well and I did well.

Now, let me backtrack; let me give you a little bit of history here to help you just a little bit. I'm going to do this quickly. The first year you're on the general surgery service the bulk of the year, but you have about four months of elective work. You can go to neurosurgery for a month, you can go to orthopedic surgery for a month, you go to neurology, usually, for a month, and you may do ENT or anesthesia for a month. Then you come back and you do the rest of the time, about eight months, on the general surgery service. It's very intense, and you really get ground down very good.

The first year I made two major political mistakes. Here's the first one. I really enjoyed urology and made some overtures to Dr. Edson, who was the chief of urology. He later left and went to Washington Hospital Center, and Kevin O'Connell took over. I made overtures with Dr. Edson that maybe I would like to be a urology resident. Part of the reason was I loved Edson, who is such a calm, mellow person and urology was a lot less intense than general surgery. I was maybe just looking for a respite from the

storm, as it were; I'm not sure how you'd put it. The problem was that's not how you do that. You can't switch residencies from one to the other. I hadn't talked to anyone in the general surgery department. I'd just talked to Dr. Edson, and I had just simply asked, "Is it possible I can do this?"

Anyway, Edson goes back to the general surgery department and says something to the chief, who says, "What's Robinson doing over there talking to you?" That was a major political error, there's no question about that. It should have been done much differently than the way I did it, but I didn't know that. I didn't do it maliciously at all. I did it out of ignorance. I just went down that hole and that was the wrong hole to go down, which put a little mark on my head.

I'm now in neurosurgery, and neurosurgery was Dr. Cal Early. I had gone up on the wards; this was in the old hospital and these wards no longer exist. There was a custodial ward for neurosurgery patients in those years, and there were people there who were in vegetative states; today there are much different phrases for it. There was one fellow who had had an asphyxiation event; he tried to kill himself by hanging himself and had ended up with an anoxic encephalophy. There were people that had had strokes, and there were all sorts of different degrees of cognitive abilities and consciousness. For whatever reason (this is in the 70s) we didn't move them out as quickly. We shipped a lot to the VA, but we kept a lot for many months, and they needed to be cared for. So, the junior resident on the neurosurgery service (and that was usually a general surgery resident) would end up making rounds on these people and taking care of them.

If you can imagine, it was not only difficult, it was one of those things that very few people wanted to do. I didn't particularly want to do it. I thought that the system they had was so screwed up, but the nurses, bless their hearts, did everything. The nurses were the ones that kept it all going well. There weren't catastrophes because the nurses were there. So, I partnered with the nurses as a resident. I told them, "Let's get together." I remember one nurse,

Betty Van Landingham, who was Admiral Van Landingham's wife, I believe. She was up there with me and we worked together and we did a bunch of stuff. I made regular rounds. We had a system that we started. I got all the dictations done; I started getting people moved out. We started doing things in such a way that it was almost as if we turned the lights on in that ward, and sort of said, "Hey, there are human beings here too; we're taking care of them." I'm not suggesting to you they weren't being taken care of before, but it was just as an afterthought. I didn't try to get down to the OR every day. I wanted to go down, but I thought, "I'm not going to do anything but just stand there for these long cases."

Q: Now, these folks that you're talking about, that you were caring for -- these were not surgical candidates anymore?

A: No, these were not surgery. They were only neurosurgery service patients because they had neurosurgical bonuses or events and were now in a persistent vegetative state, for the most part. Neurosurgery was the parent service. I'm talking 1977, 1978, I'm talking 35 years ago; I'm talking another age. So, in any event, the bottom line is this; for whatever reason, Edson had come over and talked to the boss and the boss called Adkins. Adkins was a big boy grousing around, "If Robinson doesn't want to be here we'll get rid of him, blah, blah, blah." I think by me going to urology I stirred all this up.

Early was down there sitting in the lounge with Adkins and a couple of the other chiefs, and he apparently heard this. One day he called me into his office. This is after I'd turned stuff around and the nurses were really happy. People were really happy in neurosurgery. It was a fun place to be and things were getting done, and I wasn't always bitching and moaning about not going to the OR. I went to the OR, but I did this too. This was sort of my job, and I liked that because I had a job. I couldn't do much on neurosurgery, but I could certainly do this, and we had gotten this stuff done.

So, Early calls me down and he says, "Do you want to be a neurosurgeon?"

I said, "I'd never thought about it." And we talked. We talked very much like we're talking right now. He just sat me down in the office. Cal Early was a heck of a nice guy, and it ended up with him saying something like, "If you ever want to come over here, I'd be happy to have you in my department."

Q: But he was initiating it; you weren't at this point?

A: No, I was not.

Q: Because you had already learned that lesson.

A: Not only had I learned that lesson, but I really wasn't interested in being a neurosurgeon. I didn't want to do neurosurgery. But the point was I know he had heard people talking about, "We don't want Robinson." I think what he did is he said, "If you don't want him, I'll take him." I think that was it. If that wasn't it, I don't know. But, I mean, our discussion happened, and I said, "No."

The second year, you go off and you do a lot of things away from the general surgery department. You spend four months in trauma, four months at Children's [Children's National Medical Center], and four months on general surgery; and that's the year. In the four months on general surgery, if I'm not mistaken, you did a week or two on plastics, and a few extra things. It was a very tough year, but it was away from general surgery. The key to this year was that for the first time other surgeons and senior people got a chance to assess your abilities and skills. You were outside your department, but you were still getting an evaluation, and an evaluation which would mean a lot. You were on stage.

Well, that was the happiest time in my life in general surgery, because I was away from the intensity of Bethesda. I went down to Children's Hospital, and I did my rotation there. Jed Randolph would call me and he'd say, "Come by the office." I'd go by the office and he'd be sitting in there, reading or doing something, and he'd say, "Take my

blood pressure," and I'd take his blood pressure. This was routine; whoever was on call he'd have them come by. He had high blood pressure, and he'd just wonder what it was. He'd sit and we'd talk a few minutes, "How's it going? How's everything?" His partners were just as good. The fellows, the chief residents, were really just excellent. They were all finished general surgeons, and they were doing their pediatric fellowships.

It was a wonderful experience. You worked by yourself in the hospital; you took care of all the lines on all the kids. When you were on call you worked all night. You hardly ever saw your family. You were in neonatology, where the fellows would spend a good deal of their time. You would go and help them. You would do things there, You would help them, but that was really, really very high level stuff with very tiny babies -- no margins for error there.

Q: In this particular rotation, were you working in civilian hospitals?

A: Yes.

Q: Was there a noticeable difference in the atmosphere versus the military hospital that you were generally working in?

A: Yes. There was less rigor in the hospitals in those years in terms of how people dressed and how they did things. It wasn't Bethesda.

Now, here's the thing about the Navy residents, and this is something that happened throughout with Navy residents; everyone loved us. People would have kept us forever, because we were the most disciplined, organized, and polite. When they said, "We're making rounds at 3:00 or 3:30, or 5:30, when they gave you the start time we were there. We were there with coat and tie on. We didn't look like whatever you look like after call, because call was hell; but, on your days coming in, we had coat and tie on and were ready to go. Because of how we had been trained,

and what we were expected to do, the nurses, everyone, loved the Navy residents.

Now, what happened to me as I was leaving was very interesting. Jed Randolph called me in and he said, "Adam, have you ever thought about pediatric surgery?"

Q: Everybody's trying to feel a different interest out of you.

A: This was the most meaningful thing that had ever happened to me, because Jed Randolph was an icon in pediatric surgery. Pediatric surgery was the crucible for the general surgeons at the second-year level. That was what cut you. I mean, if you could make it there and do well -- well, not only had I made it there, but he's saying, "I will train you if you want to come back here in pediatric surgery. If you have an interest I'd like to have you come back."

Q: Did you?

A: I did not. I did have an interest in PEDS. I loved PEDS surgery, but I didn't want to do that. I was so overwhelmed with what he told me, and I always appreciated that more than you'll ever know. I got the best marks out of that rotation of any resident in my group, and that wasn't the way it had been for me.

The other thing was it validated for me, and I think it validated for my bosses, the fact that maybe Adam isn't up to your standards, or maybe he can't do what you can do, or maybe there are things you may not like; "But listen, I'll take him. If you don't want him, send him here." That was very affirming, because these were major players. The same thing happened to me in trauma at Suburban, same thing. The Timmies?? there loved the Navy, and I had a great rotation, a great four months. The Navy residents were just the best. I think traditionally, military residents -- Walter Reed, Army, Navy, Air Force -- have wonderful residencies. I think that the discipline that we have in our programs is what the civilian programs see, and at least in those years they wanted to have some of that.

Q: That was validating for you to have him ask you that.

A: It was validating for me to have that. It was also validating for me to know that what I was doing was really on par with everyone. I had that in my civilian first-year at Southern Illinois in which they asked me to stay with them, but I had not had that for the year at Bethesda. During my time at Bethesda I worked hard. I thought I was doing okay, but there were no strokes in those years, so I didn't know how I was doing. I had to go out and have other people tell me how I was doing, because I had no way of knowing. If I said to you, "Jan, I'm doing fine." How the hell did I know I was doing fine, particularly if the boss says I'm not doing fine? The boss never said I wasn't doing fine, but I never had a chance to do the cases.

Q: They wouldn't give you a case, so you probably wondered about that at some point?

A: I wondered about that a fair amount. I decided that I needed to make sure that I did what I could in neurosurgery. I said, "Alright, I can't do surgery right now, but here's what I can do." I was never going to just grouse about what I wasn't going to do, I just did what I could do.

There's one other thing that Bob Cochrane told me. When he came down when I took over as the commander at Bethesda, he said, "Robbie, you're sitting in my house (the same room I'm in now with you). It was in the beginning of the evening, and my wife had made a bunch of really wonderful, tasty hors d'ourves and things. He had a glass of wine and was fully relaxed. "Robbie, you are just hell on wheels. You were always so intense."

I don't think that Dr. Cochrane, nor anyone else, recognized the pressure that I was under. I don't think they really quite understood that, even if they were helping me in doing things. It's like the patients that I saw as a chief resident at the clinic in Bethesda with Bob Cochrane. (I'm going to be his visiting professor at West Virginia in May). I was very popular, always, with the

staff and the patients. I had huge numbers of patients that wanted to come and see me, and I'd see everybody. I mean, if you came in and said, "I want to see Dr Robinson," then "Come back at 3:30 or 4:30 or 5:30, I'll see you then." I hardly ever turned anyone away, because I figured if you're here I'll work you in, in some fashion, if you can just wait. So, most people did.

Well anyway, this lady came in and she needed a breast biopsy. In those years we were doing breast biopsies in the back of the general surgery clinic. It was a really nice system that we had; it was an ambulatory surgery system. The corpsman came to me and said, "Dr. Robinson, you have to see the patient in such-and-so. Dr. Oliver has seen her and she doesn't want to see him." Well, Dr. Oliver, who is now a professor at Duke University in orthopedic surgery, happened to be an African American intern that was on my service. I couldn't understand why she didn't want to see him. Trust me, I wasn't putting it together why she didn't want to see him. My corpsman, I'll never forget him, was giggling because this woman had demanded to see his boss. Well, his boss was me, and the corpsmen were getting a big kick out of this. They knew what was going on, but I didn't. I had so many people to see, and I said, "Fine."

But they said, "This woman is coming from the Pentagon. Her husband's a commodore, and she knows people."

In any event, I went to see her. I walked into the room and the corpsman came in with me. She said something to the effect of "Oh my God, I can't get away." I had no idea what this woman was talking about. Forgive me, but I wasn't tuned in; that's not where my mind was. I examined her, and she calmed down. She had a nodule that was very well defined; it was lateral. I said, "Ma'am."

She started saying, "My husband's on the way," blah, blah, blah.

I said, "Ma'am, we can do this right now."

"Right now?"

"Yes, ma'am. We'll do it right now." This was in March or April of '82, three or four months before I finished, so I was at the top of my game. I mean, I was doing everything then and I was working. I took her back and did the biopsy. I gave her a little bit of sedation, which was a mistake because she couldn't drive home; so the issue, then, became, "Well, how can I go home?" This wouldn't happen that way today for a lot of reasons, but the point is in that year at that time, and as a chief resident in surgery, I actually had the power to do that.

I had taken care of this woman. It turned out to be a benign lesion. Post-operatively she had no issues at all, no infections, no hematomas, no nothing; she did beautifully. Someone came to pick her up and took her home. The next day, the admiral, who at the time I believe was Admiral Crews, got a call from someone in the Pentagon complaining about what I had done and who she had taking care of her at the hospital. Cochrane called me into the office and said, "Tell me, what in the world did you do with Mrs. Jones (a made-up name)."

I said, "I'll tell you about Mrs. Jones. She came in, but she didn't want to see Barry. I don't think she wanted to see me and I think the reason she didn't want to see me…" I'd obviously had a chance to think this one out and also talk to the corpsman and find out what had happened. She'd said a lot of things to them when no one was there; she didn't want to see any more black physicians. So when the chief resident comes in and it's me, she was like, "Oh my God."

I took care of her. She never said nor did anything to me to make me think that she did not want me to take care of her. And not only that, she was absolutely ecstatic that I would take care of her and got all results for her. The only thing I can say is that I had no idea that there would be a complaint. Cochrane got it, and this is one reason why

I love Cochrane, and the reason that I'm telling you this is that Cochrane was such a friend. Cochrane got the complete story and he said, "Robbie, thank you very much." I never heard another word about that. To this day, I've never heard another word.

Q: That's a great story.

A: That's a true story. That one is true from the beginning to the end. I never heard another word. But it exemplified the kind of BS and the kind of nonsense that goes on in situations regarding things like race that have no place, have nothing to do with what's occurring. And it's interesting, because I can tell you this, she may not have liked me, but she certainly liked the care she got.

Q: It was one-stop shopping.

A: It was a one-stop shop. She may not have liked exactly what was happening. The complaint was that I had done all these things but hadn't pre-arranged her getting home, so she needed to wait to have someone pick her up.

Q: That was the only thing she could say.

A: Well if you want to know the truth, and I really mean this, it's absolutely true that as a matter of fact today, Jan, there's no way in the world you could ever go any place, be treated and then be asked, "Okay, how are you getting home?" That's a pre-OP prep question now. "How are you getting home? Who's going to be here to pick you up?" If somebody's not with you, if you can't designate a person so the staff knows who it is, and they can't have eyeballs on that person, then they won't do it. But the point is, that was it, and that's a true story.

I think it's a very telling story. It tells a lot of things, especially I think for Cochrane. I think he understood quite well what I was going through. He knew a lot more than I did about a lot of different things.

Bethesda was a very, very interesting place. It was a good place, and I enjoyed it. I will tell you that after I finished there, it took me a couple of years to come down from that -- it wasn't manic -- but a heightened state. It was almost like the post-traumatic stress they talk about now, the hyper-alertness. In a way, that's how you were at Bethesda.

Q: Well, you were essentially on trial the whole time you were there.

A: Yes, I was on trial for a great period of time. As a chief resident, when one of the staff in orthopedics came and asked me to do his surgery in which most kinds of things would occur, when I knew more of colon and rectal surgery as a chief resident than some of the senior attendees did because I'd spent so much time with Lee Smith, when I used to run that place and they used to come and get help from me because they just didn't know; those were things that affirmed for me that I was pretty good at what I was doing. But it took a long time to figure that out because I wasn't given that feedback.

Q: You never knew where you stood?

A: I never knew where I stood. You know, it's interesting you say that, because at Bethesda it's not a tradition that had anything to do with me. It's just a Bethesda tradition of "something that we don't do". It's not nice, but it's what we did in those years. At Bethesda, for many years, there were always three general surgery resident slots, but for years, Bethesda only finished one or two. It's over and you get fired. By the way, they didn't fire an African American; I mean, I was the only one there.

Q: But you knew this ahead of time?

A: Well, I didn't know about it, but when I got there, I found out.

Q: You found out when you were there that they had three slots and usually one got fired?

A: Yes.

Q: So you were thinking…

A: Well, I didn't know that I was going to be in the program. I did not know that I would finish the general surgery program until the general surgery party we had at the end of my second year, when I finished the Children's and Suburban rotations. We had a big party and Claude Adkins came by towards the end of the party and says, "Robbie, you know what? We're going to keep you." I'm not making this up; he said that at the party. And I said, "Oh my God, I get a chance to stay." That's the first time that I was told that I was going to stay in that program. You may ask, what are you talking about? Your first two years were junior residency years, third and fourth years were senior residency years, and then you were chief resident in the fifth year. The transition point from second to third year, wasn't a guarantee you were going on, and they could cut you off.

Now, when I became a program director I told my staff, "Let me tell you guys something" (Guys are men and women; I had women too). "Don't come to me at the end of someone's second year, and tell me you're dropping them…"

(Part II-B recording ends abruptly)

(Part II-C Recording begins in middle of conversation)

A: …and certainly not at the end of the third year. The men and women who are coming into this program have a right to know at the end of a certain period of time if they're going to be in this program and we're going to finish them. It's our responsibility to decide whether they can or cannot make it in this program long before the end of their second or their third year. We need to do that at the end of their first rotation in their first year.

If we need to make an adjustment, then we need to allow people to make that adjustment and move on with their lives, but we can't disrupt people's lives and their families like this." I felt it's absolutely unjustifiable that you hold someone in as tough a residency as general

surgery for a number of years, and then at the end of this thing, say, "We're going to cut you lose."

Q: You'd know long before then whether they were going to cut it or not. You'd know it after the first year.

A: I think you'll know it, yes. I think you know it after the first year. I think you actually know it before that, but I think it's incumbent upon the staff. And you see, what the staff doesn't understand, often, is that inability to understand someone or to be able to like someone or to communicate well with someone or to be simpatico with someone doesn't mean that they're not good. It means that you're not able to relate to them for whatever reason, but it doesn't necessarily mean it's their issue.

So, you really have to work hard to figure out who you are, where you are, what you are, and what you're trying to get done in relationship to the people you're working with. The teacher's responsibility is always to the student. The student's responsibility is not to the teacher.

Now, the Japanese have a very interesting thing that I think exemplifies what I'm saying. When you are a student with a sensei, a doctor, a master, you wash his clothes, you sweep the house, you cut the grass, you work and do all the menial things for this person. "Well, Adam, you just said that it's not the responsibility of the student to do things for the sensei." That's correct. What you're doing is you're making the sensei's life a little bit easier so that the sensei can direct his or her attention to you and give you exactly what you need in order to progress from where you are to being a sensei. But the responsibility is always on the sensei to understand who you are and what it takes in order to get you to transition to where the sensei is.

Q: That's a very un-Western way of looking at it, isn't it?

A: But that is a very true way of what teaching is all about. I recognize that if I ever take a student and I have him coming over to my house cutting my grass, I'm probably

going to be doing that for the last time. But the point is it's not the grass; it's the commitment of the student to the sensei to say, "I want to be with you." Then it becomes incumbent upon the teacher to say, "And I will teach you." There's a lot more to that, but I think that I'll end there by just simply saying that's our responsibility.

The residency in general surgery at National Naval Medical Center prepared me for everything that I did professionally in medicine and in surgery. When I left Bethesda and went to Yokosuka and then the *Midway*, I was prepared for everything that happened. There were no deficits in my training or abilities. The key thing was, and this is the most important thing, I had no lack of confidence to do my job. It allowed me to then go to the University of Illinois affiliated Carle Clinic as a colon and rectal surgery physician. When I went there I was a fine surgeon already, because I'd had two years as a general surgeon working in the real world doing that. I was able to really focus on colon and rectal surgery. Then I came back to Bethesda and spent five years working as an attending in colon and rectal surgery. So my confidence allowed me to do everything, and then take over as chief of surgery at Portsmouth. It was a progression of experience, and there's no question that my foundation at Bethesda did that. I've always understood that Bethesda set me up for success in the future, because it was the place that honed my professional skills and abilities and allowed me to go forward.

Q: That might be a good place to stop.

END OF INTERVIEW